Exhibit B

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AUTOPSY REPORT

Autopsy Number:	A14-051
Date of Report:	12 August, 2014
Name of Deceased:	WRIGHT, Steven O
Age:	70
Sex:	Male
Date of Birth:	Redacted
Date and Time of Death:	3 August, 2014, 0930 hours
Date and Time of Autopsy:	7 August, 2014, 1100 hours
Place of Autopsy:	Kimball Funeral Home Pullman, Washington
Responsible Party:	Pete Martin Whitman County Coroner Colfax, Washington
Prosector:	Jeffrey M Reynolds, M.D., Pathologist

FINAL PATHOLOGIC DIAGNOSIS

I. LARGE, ACUTE RIGHT FRONTOPARIETAL SUBDURAL HEMATOMA.
   - A. ONSET LESS THAN TWENTY-FOUR HOURS PRIOR TO DEATH.
   - B. NO SUBARACHNOID HEMORRHAGE.
   - C. NO SKULL FRACTURE.
   - D. HISTORY OF CHRONIC ANTICOAGULANT THERAPY.

II. MODERATE TO SEVERE PULMONARY EMPHYSEMA.
   - A. APPROXIMATELY 7 / 10 SEVERITY.
   - B. ACUTE HILAR PULMONARY EDEMA.
     - 1. ONSET LESS THAN TWENTY-FOUR HOURS PRIOR TO DEATH.

III. HYPERTROPHIC CARDIOMYOPATHY.
   - A. HEART WEIGHT – 658 GRAMS.
     - 1. NORMAL FOR PATIENT WEIGHT – 450 TO 500 GRAMS.
   - B. MODERATELY SEVERE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE.
     - 1. NO EVIDENCE OF MYOCARDIAL INFARCTION, RECENT OR OLD.

IV. CAUSE OF DEATH: ACUTE SUBDURAL HEMATOMA SECONDARY TO FALL AND ANTICOAGULATION.

V. MECHANISM OF DEATH: DECREASING RESPIRATORY EFFORT SECONDARY TO INCREASING INTRACRANIAL PRESSURE.

VI. MANNER OF DEATH: ACCIDENTAL.

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BRIEF HISTORY

Deceased found dead in his bathtub at home with no evidence of foul play in the area. Deceased is known to have atrial fibrillation, COPD, hypertension, obstructive sleep apnea, and hyperlipidemia. Deceased is status post bilateral hip replacements and has been on anticoagulant therapy for years.

Recent history notable for a fall with strike to right forehead while leaving emergency room the night before death.

EXTERNAL EXAMINATION

Body is that of a Caucasian male appearing approximately his stated age, measuring 70 inches in length and weighing 280 pounds.

HEAD – Hair is gray in color, clean, averaging 1 to 2 inches in length with bifrontal receding hairline in the male pattern. Superficial abrasion is present on the left frontal scalp, measuring 2 x 4 cm. Only mild swelling present in this area. No discharge from the mouth, nose or ears is seen, but there is dried blood tinged material present in the oral cavity. No evidence of mechanical damage to the teeth, tongue or lips is seen. No damage to the scalp is visible or palpable. Eyes show conjunctival injection bilaterally with a subconjunctival hemorrhage laterally on the right. Pupils are equal, round, mid position bilaterally with arcus senilis prominent on both corneas. Anterior chambers are clear, and irises brown in color. A black and gray goatee is present, which clean and neatly trimmed. Beard growth estimated at several days.

NECK – Anterior structures are mid line and mobile, and the neck appears atraumatic and unremarkable.

THORAX – 4 cm inferior and 2 cm medial to the right nipple is an area of bruising measuring some 5 x 3 cm in largest dimensions. No skin damage is noted. No other bruising is present. The chest is symmetrical and otherwise unremarkable.

ABDOMEN – The abdomen is protuberant with a lower pannus, and punctate hyperpigmented areas of varying age consistent with carbuncles or subcutaneous injection sites.

UPPER EXTREMITIES – Superficial punctate and linear scarring measuring anywhere from 1 to 3 cm in diameter in length present over the dorsal aspects and lateral aspects of the upper extremity and superior shoulder region. These are old and well healed except for two or three, which show areas of hyperpigmentation and more recent healing. The right hand is atraumatic with nails neatly trimmed and mildly soiled and overlapping ¼ inch. The left upper extremity and shoulder show similar punctate lesions, although a large, well healed surgical scar is present over the anterior left shoulder. This is old and well healed. Some bruising is present in the left antecubital fossa consistent with recent intravenous access. Nails are similar to those on the right and there is no evidence of defensive or offensive trauma to either hand or forearm.

PELVIC REGION – Genitalia are circumcised male with both testes present intrascrotally, and

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small amount of hazy discharge from the urethral orifice is noted. No anal discharge is present. No evidence of trauma to the pelvic region is seen.

LOWER EXTREMITIES – There is some swelling of the left lower leg from above the knee distally to the foot with a yellowish tinge and some areas of bruising noted in the region of the anterior knee. Collections of bruising on the medial aspect of the left foot consistent with at least one to two days duration. No such change is noted on the right. Toenails show some early fungal involvement, but no evidence of secondary infection. No evidence of major trauma to either lower extremity is noted.

BACK – A long linear scars in posterolateral aspects of both hips noted, consistent with history of hip replacement surgery. The back is otherwise symmetrical, atraumatic and unremarkable.

INTERNAL EXAMINATION

The body is opened in the usual Y-shaped fashion revealing 2 to 3 cm of subcutaneous fat over the anterior thorax and 5 to 6 cm over the anterior abdomen. No evidence of trauma to the internal or external aspects of the thoracic or abdominal walls is noted. No appreciable amounts of free fluid are present in the pleural, peritoneal, or pericardial spaces.

HEART – The heart appears large, but the epicardial and pericardial surfaces are unremarkable. Total weight of the heart is 654 grams. Serial sectioning of the myocardium reveals dilated hypertrophy with a septum 1.5 to 2 cm thick and the lateral walls 1 to 1.2 cm thick. The right ventricular wall averages 4 to 5 mm thick. No evidence of fibrosis or past myocardial infarctions is noted. Serial sectioning of the coronary vasculature reveals proximal calcific atherosclerotic atresia to 50% of the original lumen in the left anterior descending coronary artery, similar changes in the left circumflex coronary artery, but a widely patent right common coronary artery. Valves are all delicate without evidence of atresia, regurgitation or vegetations. There is in no evidence of pulmonary embolic phenomena in the pulmonary outflow tract. Coronary ostia are widely patent and the ascending aorta shows minimal atheromatous change.

LUNGS – Both lungs are greatly inflated by emphysematous change, and fail to deflate even in section. Background chronic pyogenic bronchitis is noted, but no evidence of pneumonia or pulmonary embolic phenomena is found in any lobe. The right lobe weighs 900 grams and the left lung 705 grams. In section, there is hilar pulmonary edema bilaterally, and much less so peripherally. Some passive congestion is present, but this is not a prominent finding.

GASTROINTESTINAL TRACT – Esophagus, stomach, duodenum, jejunum, ileum, and colon are all unremarkable. The stomach is empty.

LIVER – The liver is present in its usual location and is unremarkable both superficially and in section. Gallbladder is present and contains 20 cc of greenish tan bile.

SPLEEN – The spleen is present in its usual location and is unremarkable both superficially and in section. Both liver and spleen show evidence of passive congestion, but this appears only to have

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been present for a few days rather than months.

PANCREAS – The pancreas is present in its usual retroperitoneal location and is unremarkable.

ADRENAL GLANDS – Both adrenal glands are present in their usual suprarenal locations and are notable only for mild cortical hypertrophy.

KIDNEYS – Kidneys are present in their usual retroperitoneal location surrounded by large amounts of retroperitoneal fat. Both kidneys are unremarkable both superficially and in section. Ureters are widely patent and the bladder is empty.

CENTRAL NERVOUS SYSTEM – Scalp is reflected in the usual fashion showing a small amount of hematoma present down to the level of the galea in the area of the superficial abrasion noted on the right forehead. No evidence of dissection of this bleeding laterally from the imprint noted at the skin surface is found. No other evidence of head trauma is present. Skullcap is removed in the usual fashion showing no evidence of epidural hematoma, but a large (198 cc) subdural hematoma is present on the right with an obvious left shift of the brain and pressure phenomena affecting the right frontoparietal region. A trace (less than 10 cc) subdural is present in the basal aspect of the left hemisphere. No subarachnoid hemorrhage is noted, but obvious blood loss due to pressure phenomena in the right hemisphere is present after the subdural hematoma is evacuated. Early transtentorial herniation is noted, but no hemorrhages to the mid brain or brain stem are present. In section, obvious collapse of the right lateral ventricle is noted with a mid line left shift. Contents of the posterior fossa are unremarkable. Pituitary gland is present in its usual location and is unremarkable.

TOXICOLOGY

Blood and vitreous are retained by the coroner for toxicologic analysis.

MICROSCOPIC EXAMINATION

Sections of the myocardium show multiple small foci of myocardial fibrosis, but these are microscopic in nature and no evidence of a significant myocardial infarct is present. No background myocarditis is noted, but small vessel disease is noted, consistent with untreated hypertension.

Hilar edema noted in both lungs is acute in nature, with only minimal inflammatory response by intra-alveolar macrophages noted. Severity of emphysematous change increases as you move to the periphery of the lung, with subpleural areas in the 8 to 9 / 10 severity range, while deeper areas more consistently 6 to 7 / 10 range. Pyogenic bronchitis noted grossly is confirmed microscopically, but no secondary pneumonia is found.

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